CONTACT INFORMATION

Client Name_____ Date _____

Address _____

Phone(_____)_____Email _____

DOB _____ Social Security Number _____

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General Physician Name _____

Address and Phone_____

Psychiatrist Name and Contact_____

Emergency Contact_____

Previous Therapy Providers _____

How did you hear about Empowering Counseling & Therapy?_____

_____

INSURANCE INFORMATION

Insurance Provider_____

Primary Member's Name and DOB_____

Member Address_____

Member Social Security Number_____

Member ID#_____Insurance Provider Phone_____

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Co-Pay Amount $_____ Number of Visits Approved_____

Precertification Required? Yes No

_____I fully understand that I am responsible for payment of services if my insurance copay for whatever reason does not cover the cost of services.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date